Entering a CA-1 On-line

Introduction

Submitting a claim electronically consists of two actions…

1. Initial entry of the claim information by the supervisor and the employee

2. Injury Compensation Program Administrator (ICPA) reviews the claim and submits the claim to the Office of Worker's Compensation Program (OWCP)

This presentation will focus on the first action.

Objectives

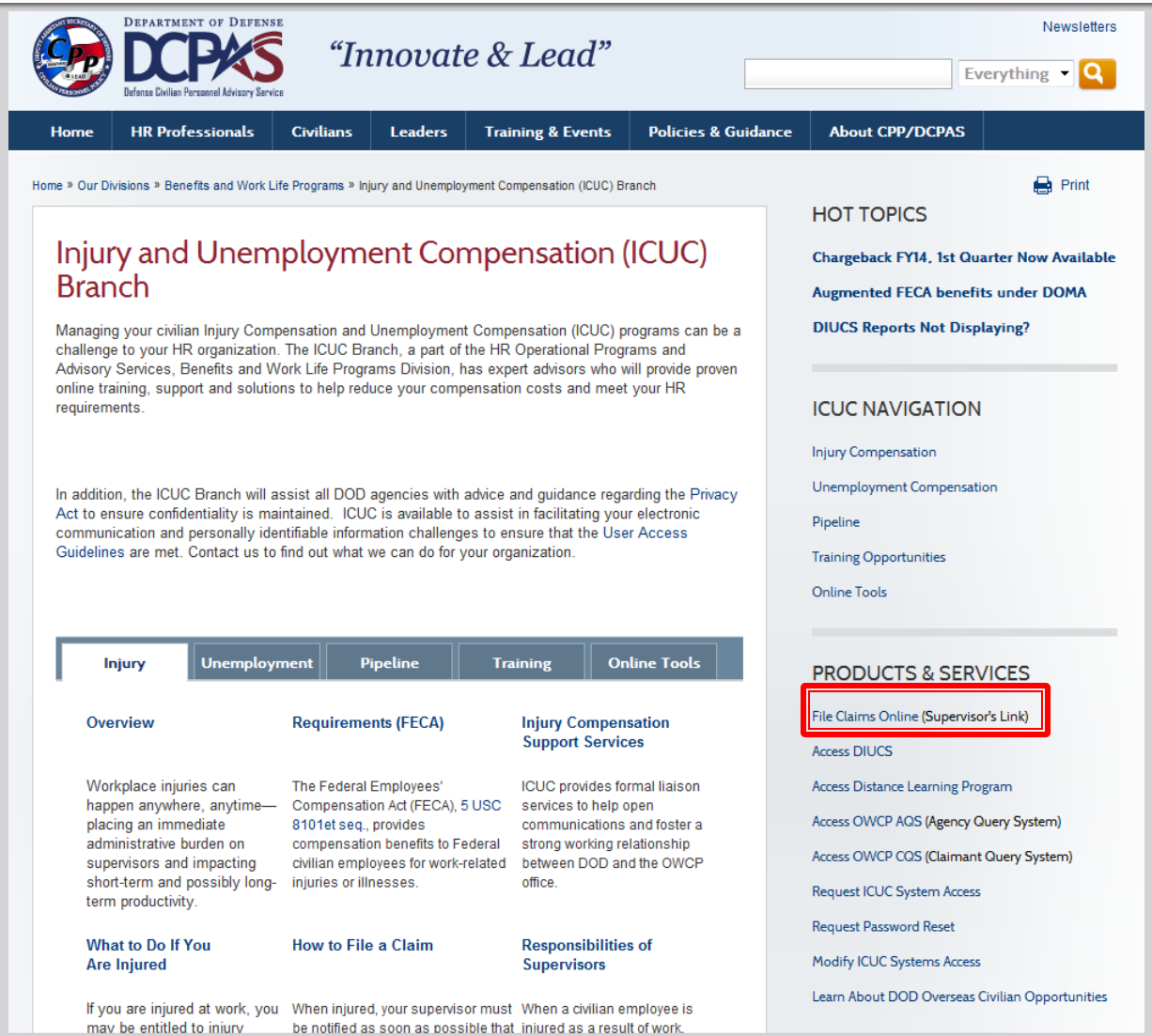
Upon completion you will be able to:

1. Access the supervisor portion of the EDI application
2. Enter information into a CA-1 form
3. Submit the form to the ICPA

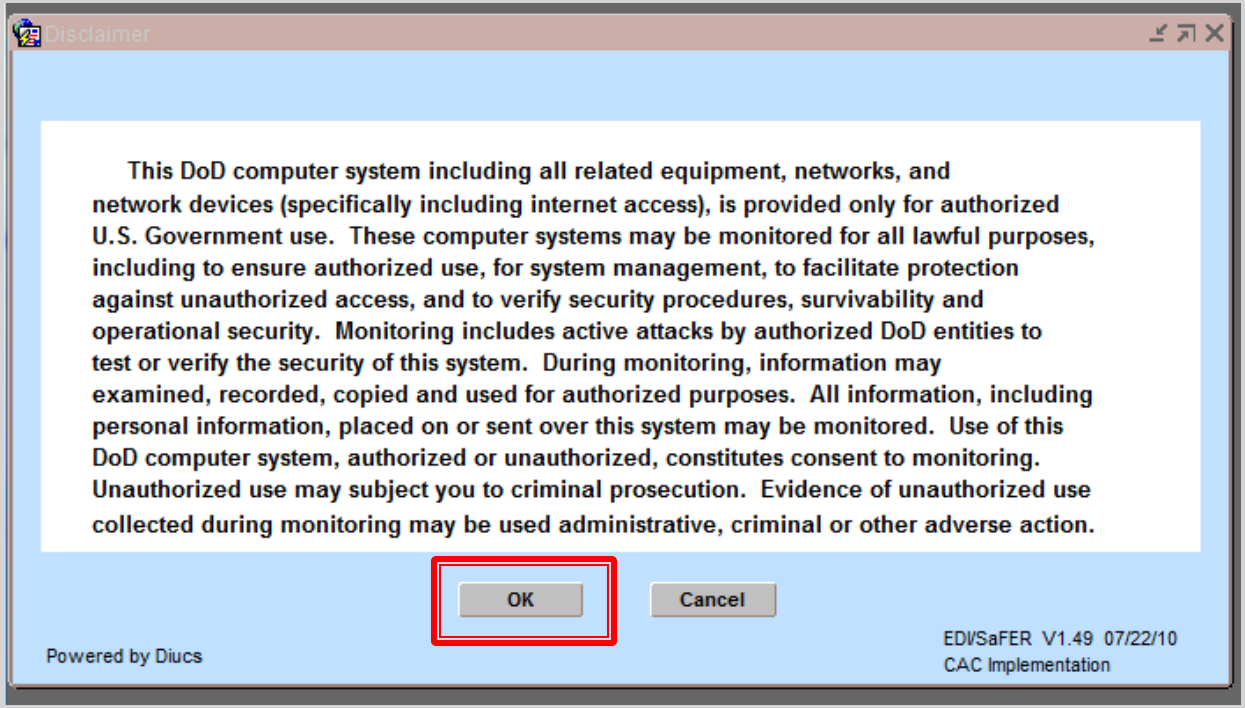
Accessing the EDI Application

The easiest way to access the EDI Application is through the DCPAS ICUC Web page.

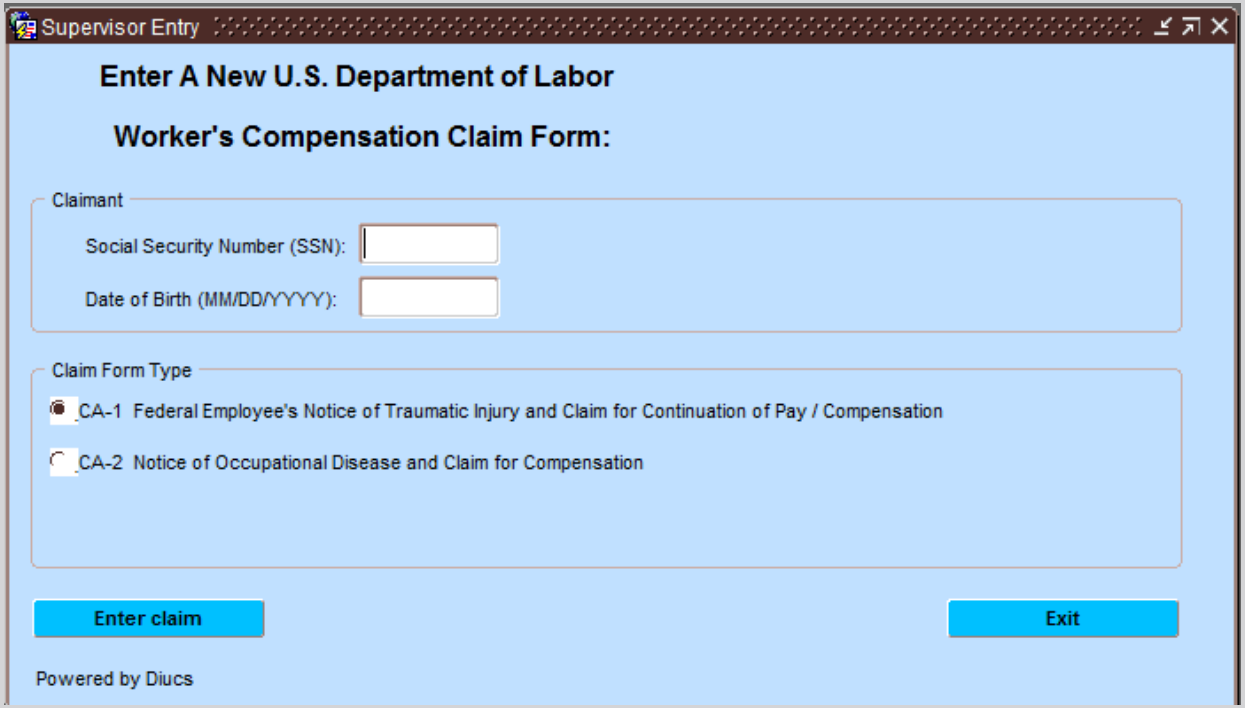
Select ***File Claims Online*** (Supervisor's Link)



When the EDI application starts, a security notification screen will open. Select ***OK*** in order to access the application.



Once the initial claim screen appears, the SSN and Date of Birth (DOB) are entered as well as the type of claim being filed Traumatic injury (CA-1) or Occupational Disease/Illness (CA-2)



The EDI application then checks information from the Personnel database (DCPDS) using the SSN and DOB to verify that the individual is an employee.

If the SSN or DOB do match any record in the database, the system will generate an error message.

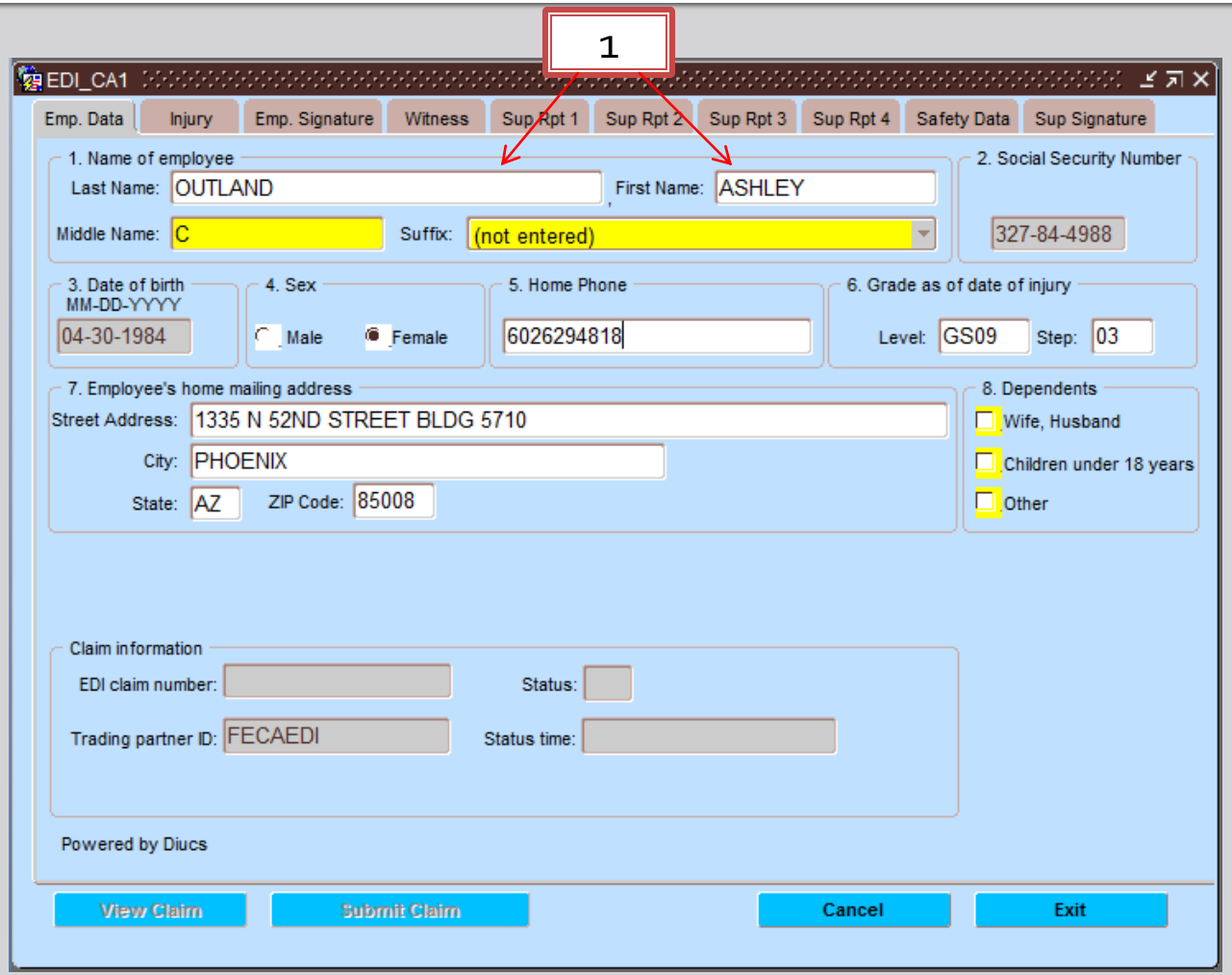
You will not be able to file electronically.

Contact your ICPA if you receive this error message.

If the SSN and DOB match a record then the claim form will open.

The claim form will then open.

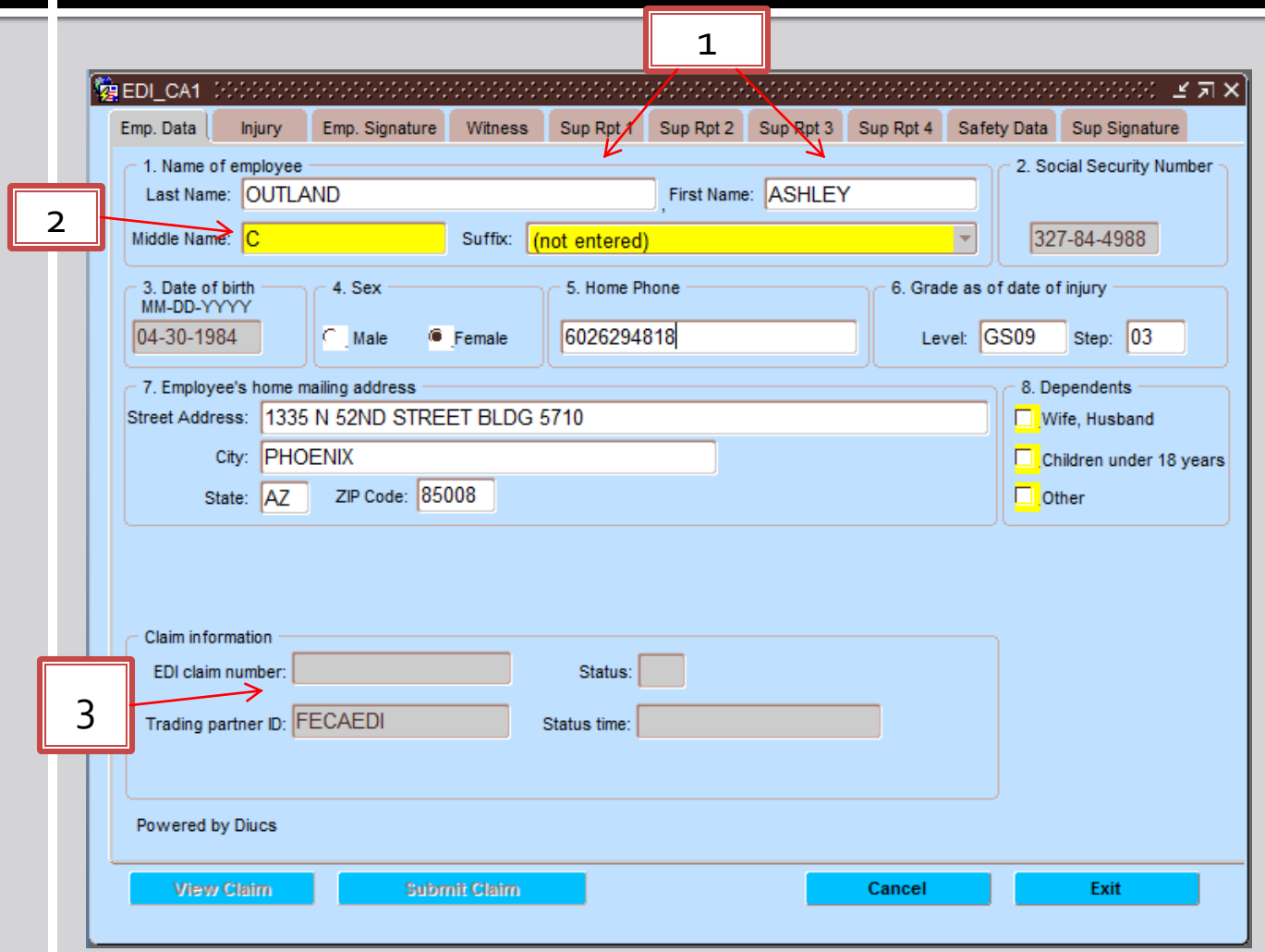
1 Certain claimant information will be filled in by the EDI application using information from DCPDS (Personnel) system.



The fields are color coded.

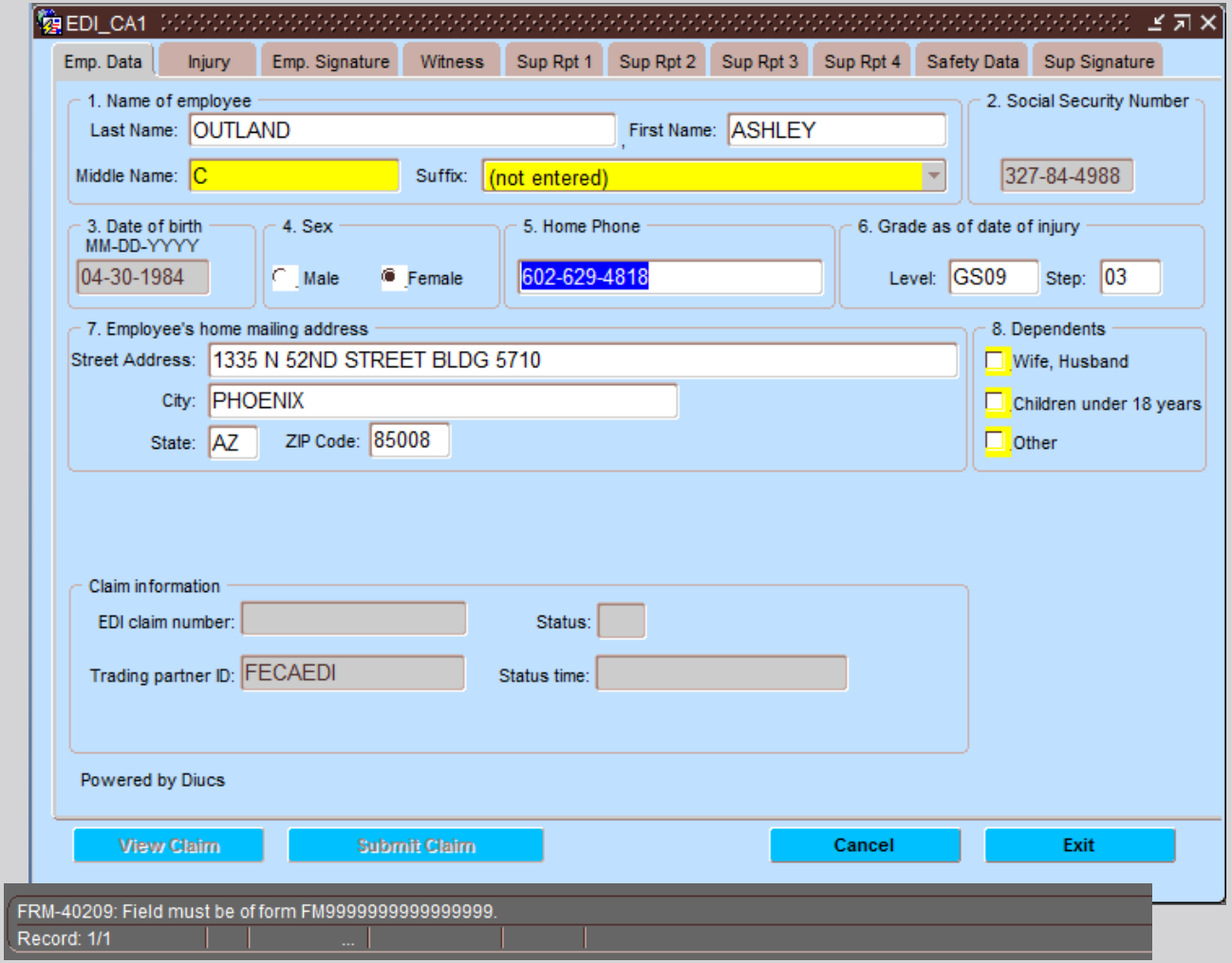
Each color signifies whether the data is;

1. required (white),
2. optional (yellow) or
3. for information only (gray).



For the required information to be entered using a particular format. If the data entered is in an improper format, the application will not allow any further progress until the information is input in the proper format.

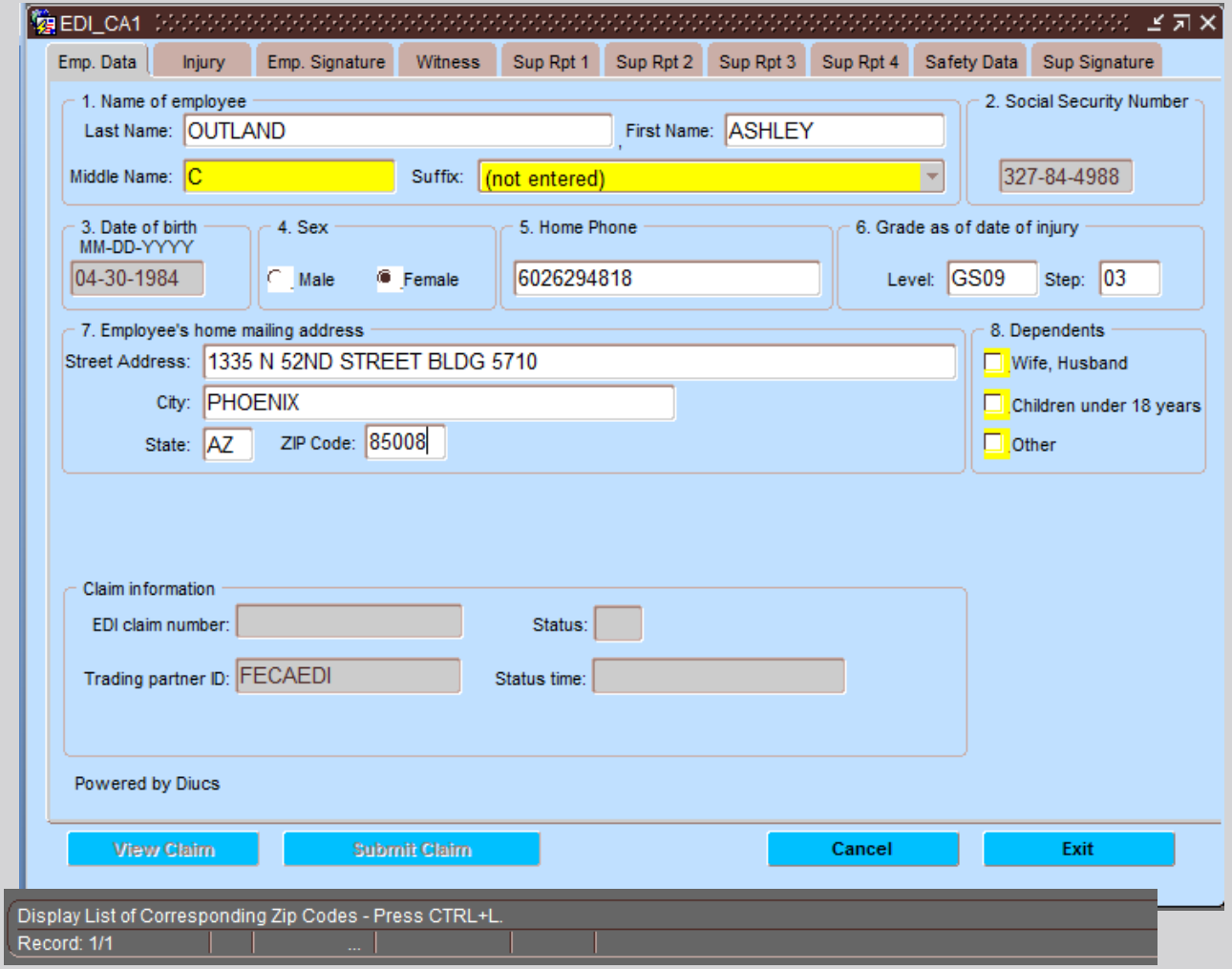
A message will display on the status bar at the bottom left of the screen alerting the user to the error and the proper format.



The application contains certain features that make it easier to enter information into the form.

Certain fields will display a searchable list of available values for that particular field.

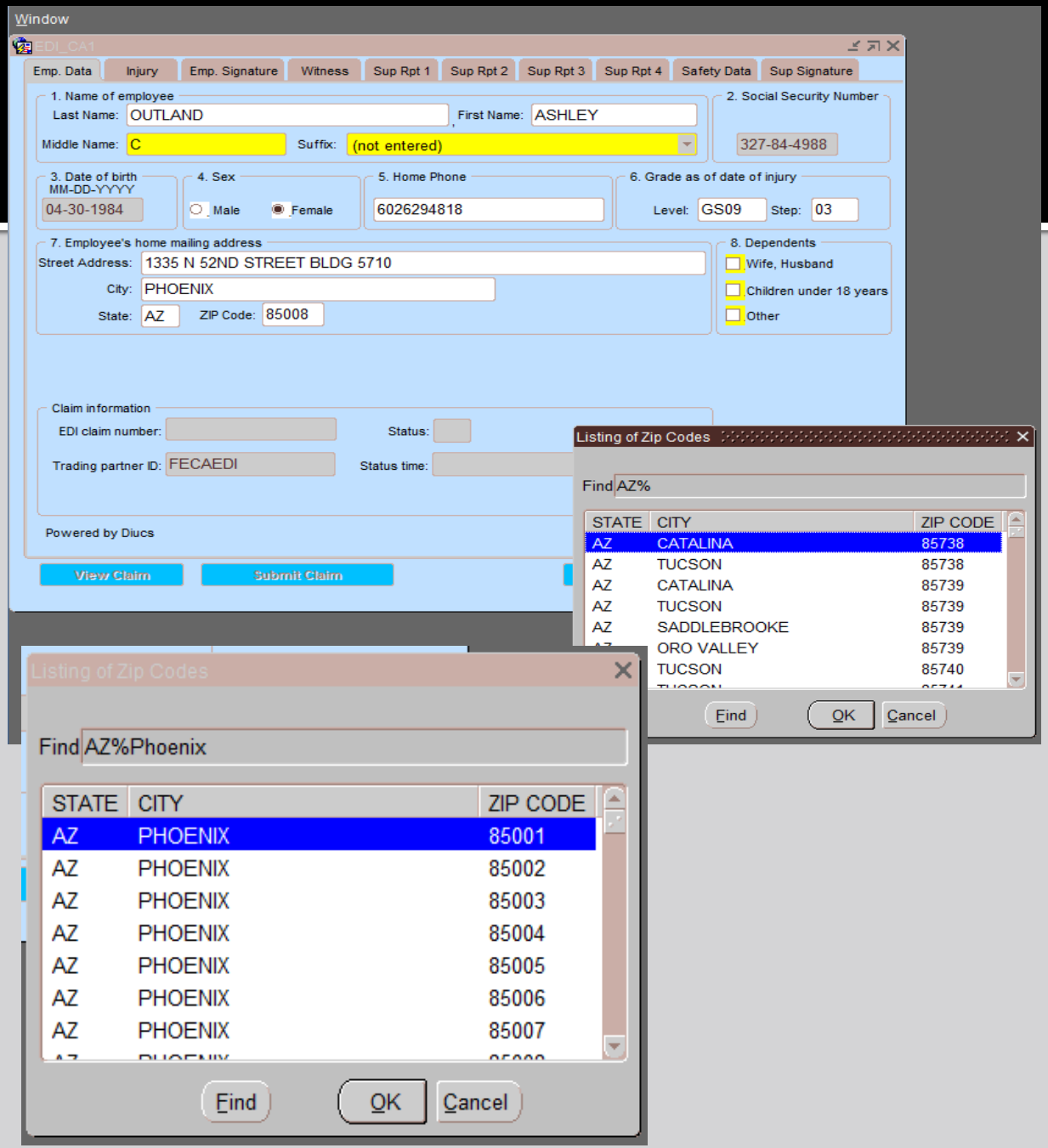
A message on the status bar will let you know that if the **CTRL+L** function is available for that field.



Employee's Data Tab

By using **CTRL+L** key combination while the cursor is in the field will open a dialog box that will allow you to search and select a value for the field.

Enter the city name next to the **%** and click the **Find** button and the list of zip codes for that city will appear. Scroll until you locate the correct zip, select, then click **OK**.



Injury Tab

The **employee** will enter information into the white fields of the claim form.

Block 9 Place where injury occurred: Enter the Work Location Address where the injury occurred. *It should be the mailing address of the location rather than just a building or work center name.*

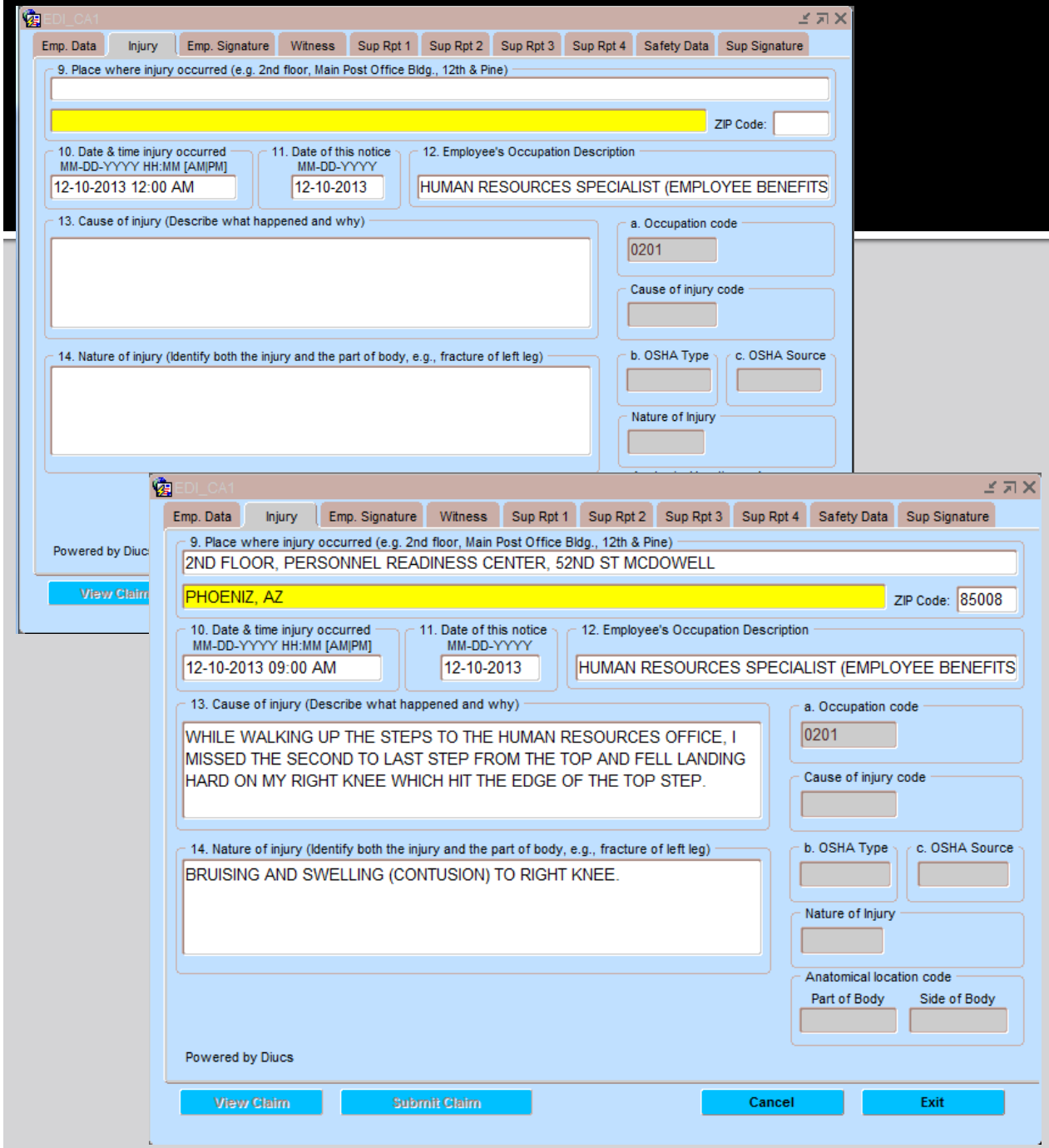
Block 10 Date & time injury occurred: Enter the date and time injury. If no time is entered then the application will enter a default time of 12:00AM. DO NOT enter time in a military format (i.e. 1700 hrs).

Block 11 Date of this notice: This field should contain the date the claim is being entered into the EDI application or the date the employee signed the paper copy of the CA-1 form.

Block 12 Employee's Occupation Description: Will automatically fill by the application based on what is in the personnel system. However, of the information is incorrect it can be changed.

Block 13 Cause of Injury: Enter the cause of the injury. Be as specific as possible . Tell how much the object weighed , how did the employee fall and from what height, what task was being performed when injured. The information provided should always be in 1st person.

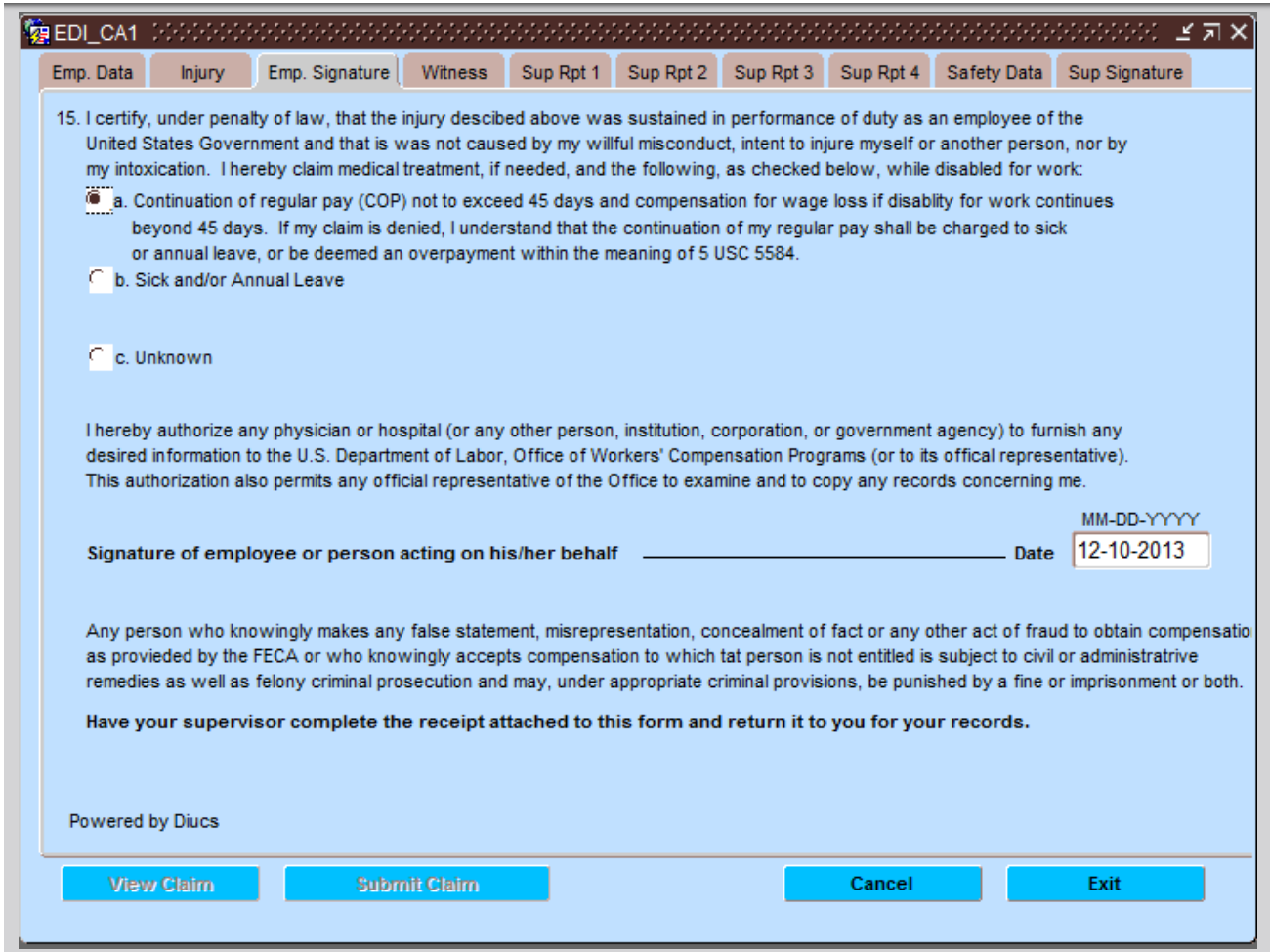
Block 14 Nature of Injury: Enter the nature of injury. Identify the injury and specific body part and/or area of injury such as sprained left knee, strained right shoulder, laceration to left middle finger, etc.



Employee Signature Tab

NOTE 1: If the employee is using Sick and/or Annual Leave during the 45 calendar days from the date of injury for any appointments related to the claimed injury counts against the COP 45 calendar days if the claim is filed within 30 days of the date of injury.

NOTE 2: Regardless of the use of COP, Sick and/or Annual leave, the leave code LU must be input for the date of injury on labor card or time and attendance.

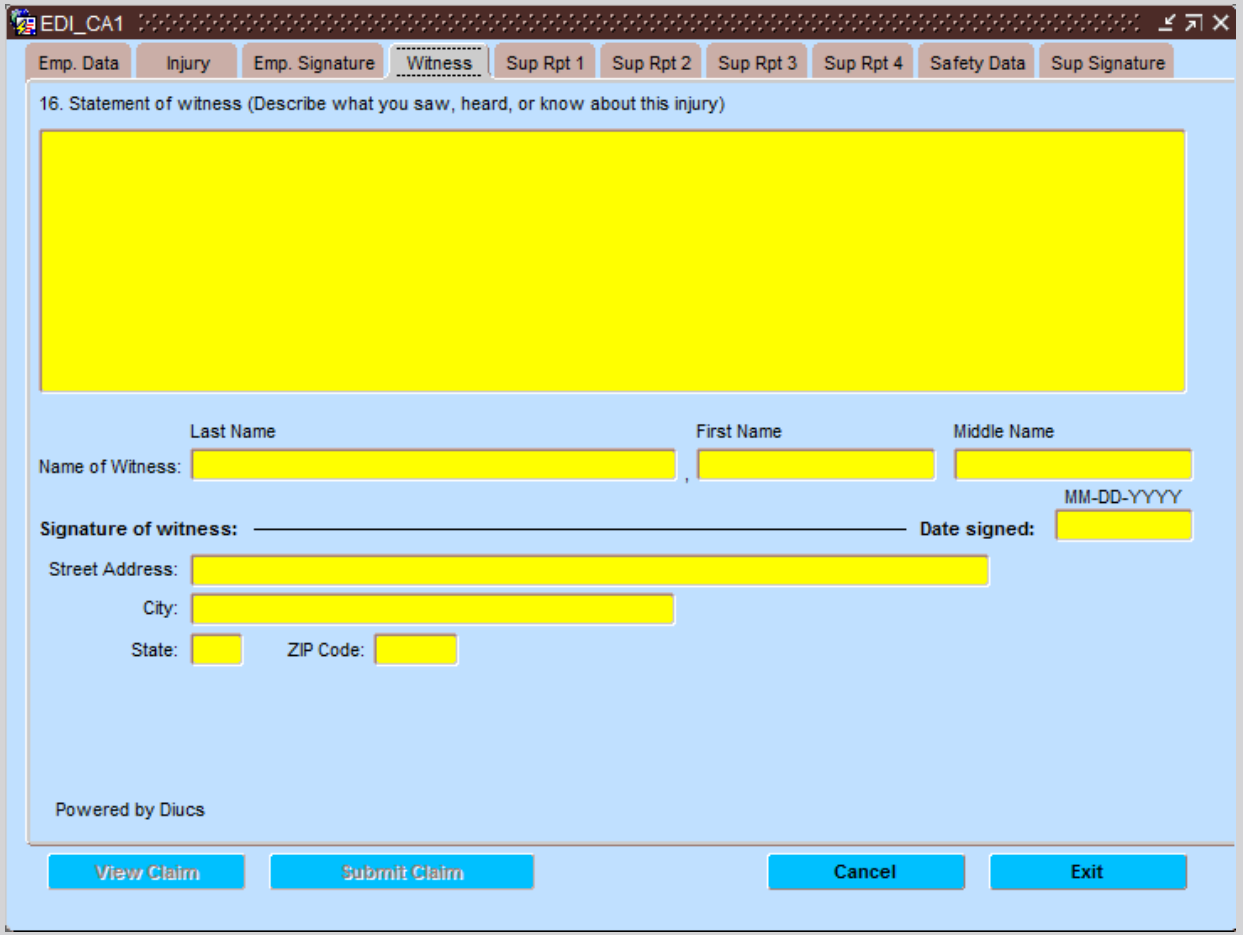


Witness Tab

If there is a witness, have them utilize this tab to input what they saw, heard or know about the claimed injury.

If there was not a witness to the injury, leave all fields blank.

If there are multiple witnesses to the injury, please contact the ICPA for assistance.



Supervisor's Report 1

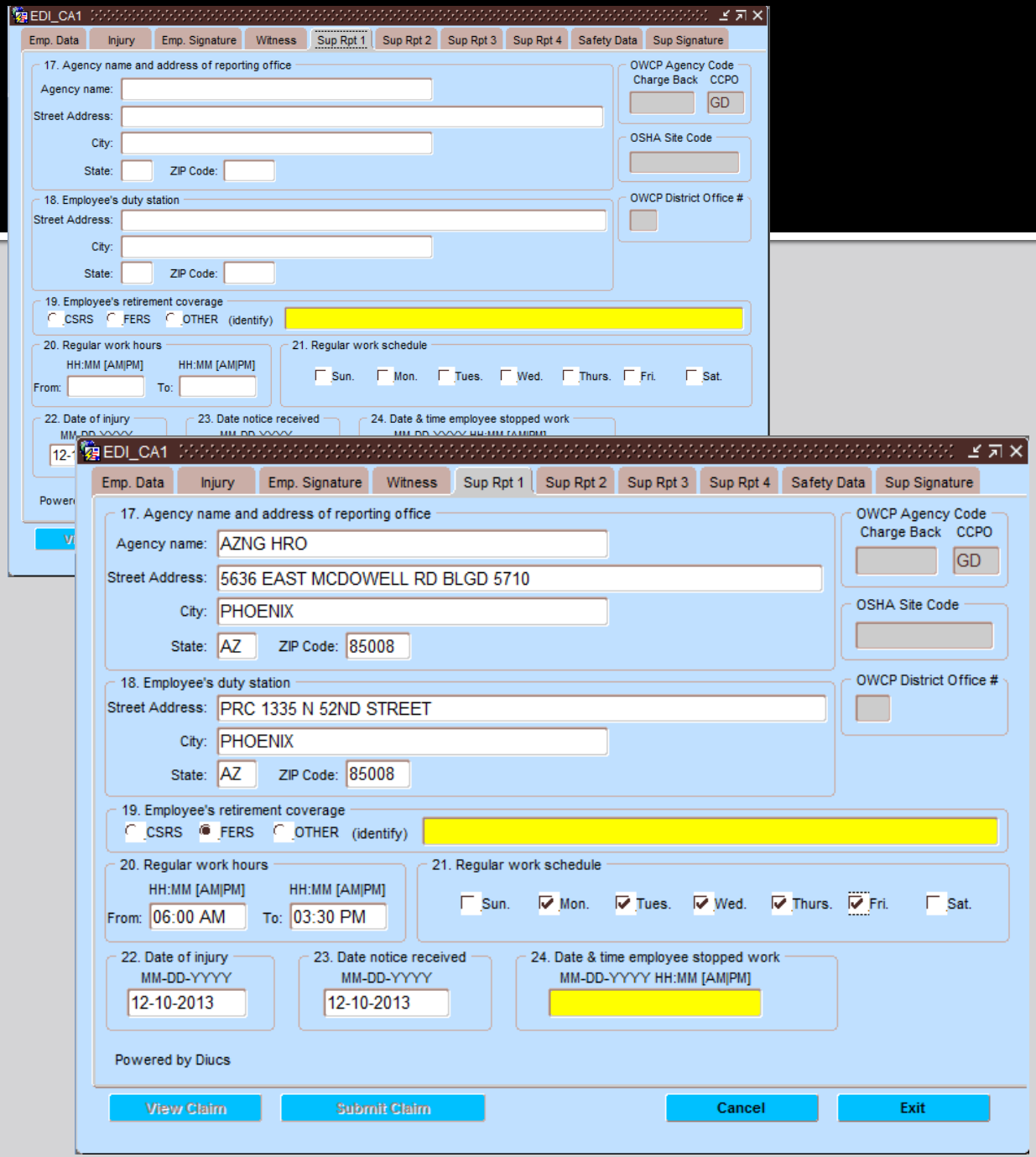
Once the employee information and witness statement have been entered, you as the supervisor, then completes the supervisor's portion of the form.

Block 17 Agency name and address of reporting office: This should always be the following:

AZNG HRO
5636 East McDowell Rd Bldg 5710
Phoenix, AZ 85008

Block 18 Employee's duty station: This should be the work location the employee is assigned (i.e. address for AASF#1 or 2, 161st ARW or 162nd FW, etc.).

Block 23 Date notice received MM-DD-YYYY: This date should be the same as the date the employee and you the supervisor signed the paper CA-1.



Supervisor's Report 2

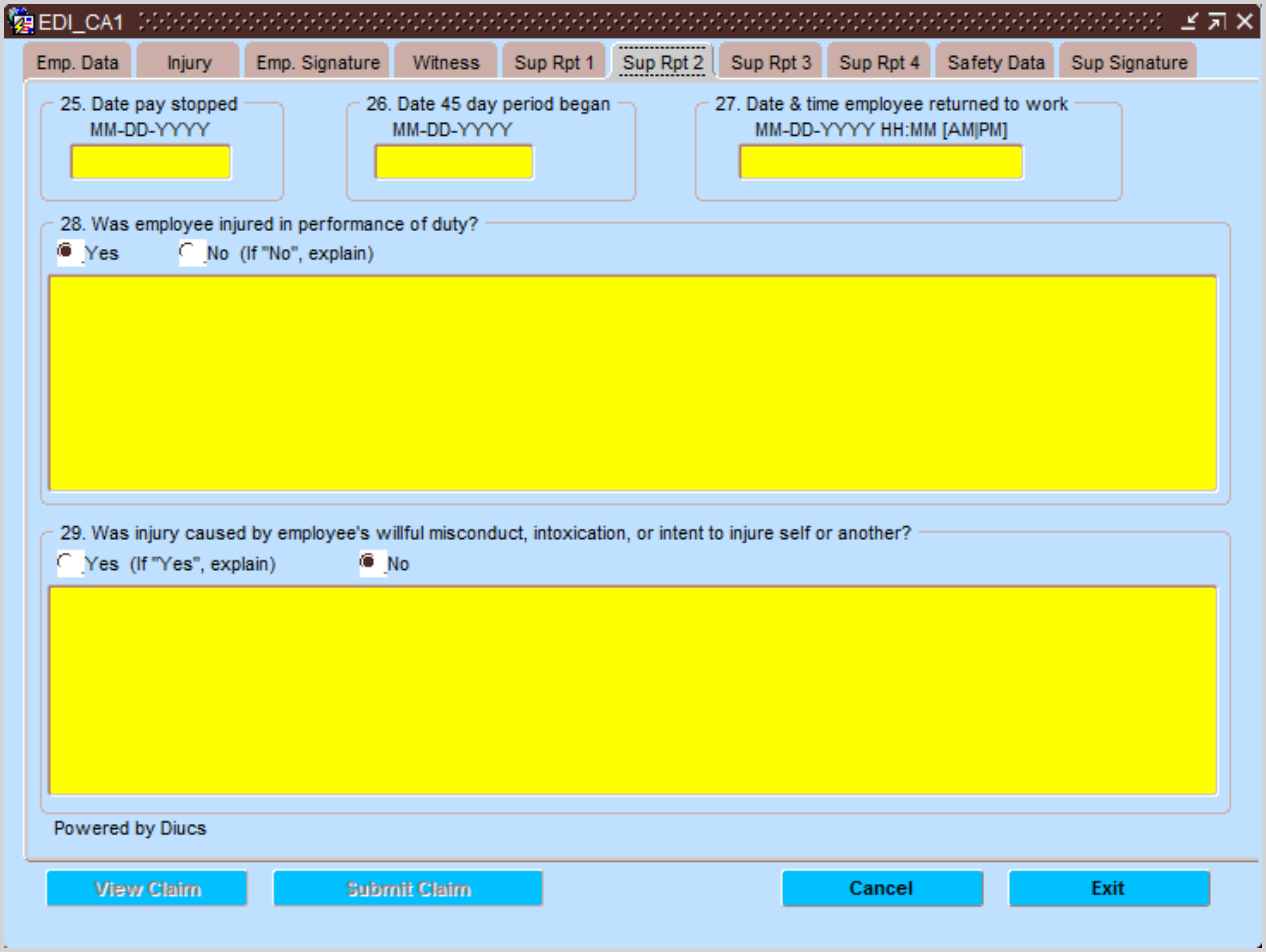
The Supervisor Report sections of the claim form are used to convey facts to the Claims Examiner (Member of the Department of Labor District Office) regarding the claim.

This is crucial especially if the agency is questioning or challenging the claim.

Block 25 Date pay stopped MM-DD-YYYY: Enter the date the employee's pay stopped not to include the date of injury.

Block 26 Date 45 day period began MM-DD-YYYY: If the employee began losing time away from work after the date of injury (DOI) enter the date here.

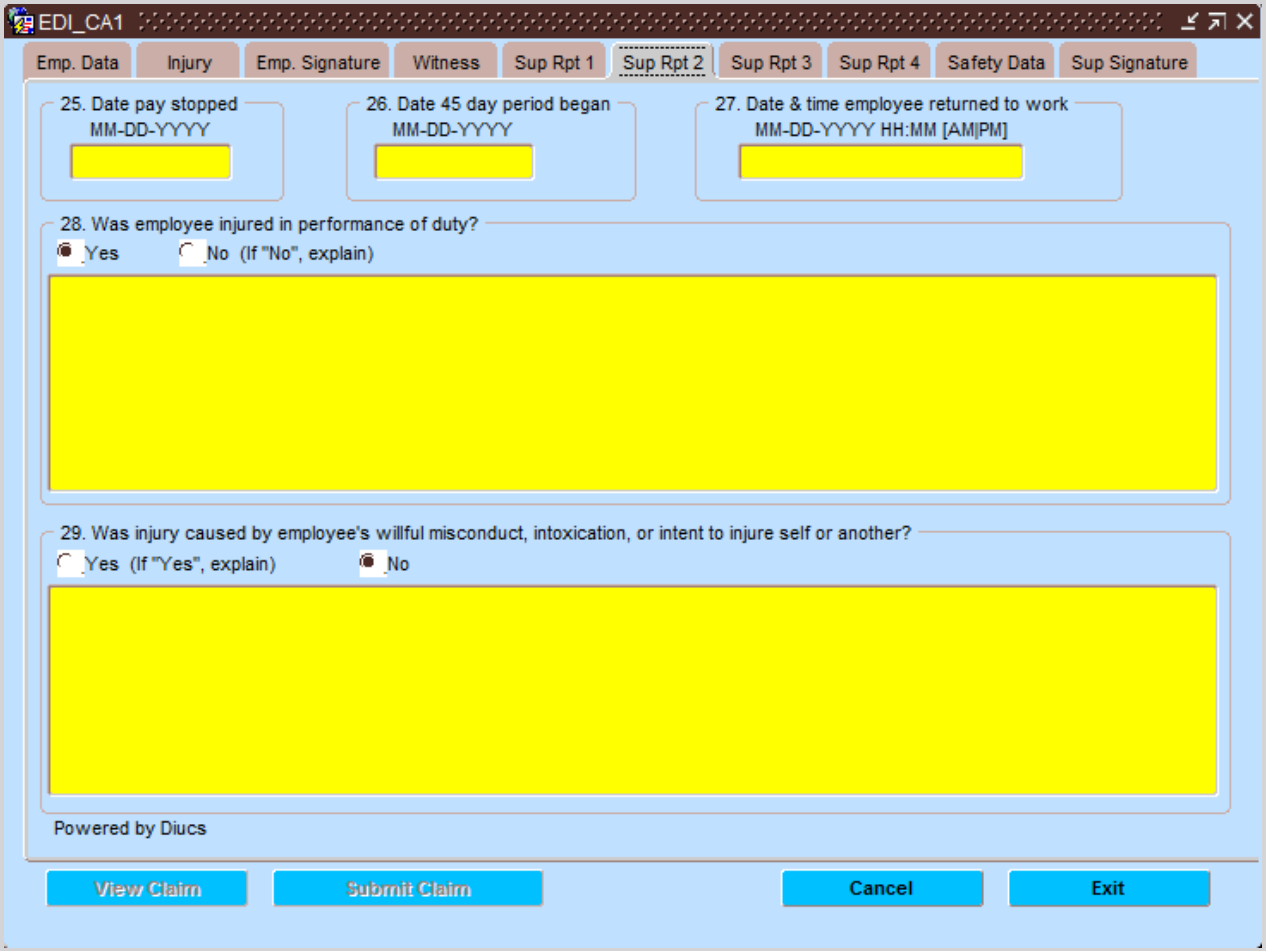
Block 27 Date & time employee returned to work: Enter if there was a date input in Block 24 if the employee was instructed by treating physician not to return to work due to the injury.



Supervisor's Report 2 Cont.

Block 28 Was employee injured in performance of duty? If you believe that the employee was not injured in the **Performance of Duty,** select **No** and enter the pertinent information into this block and contact the ICPA.

Block 29 Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? If you believe that the employee willfully sought to injury or cause injury to another, performing task while noticeable intoxicated or intentionally doing the tasking incorrectly, select **No** and enter the pertinent information into this block and contact the ICPA.

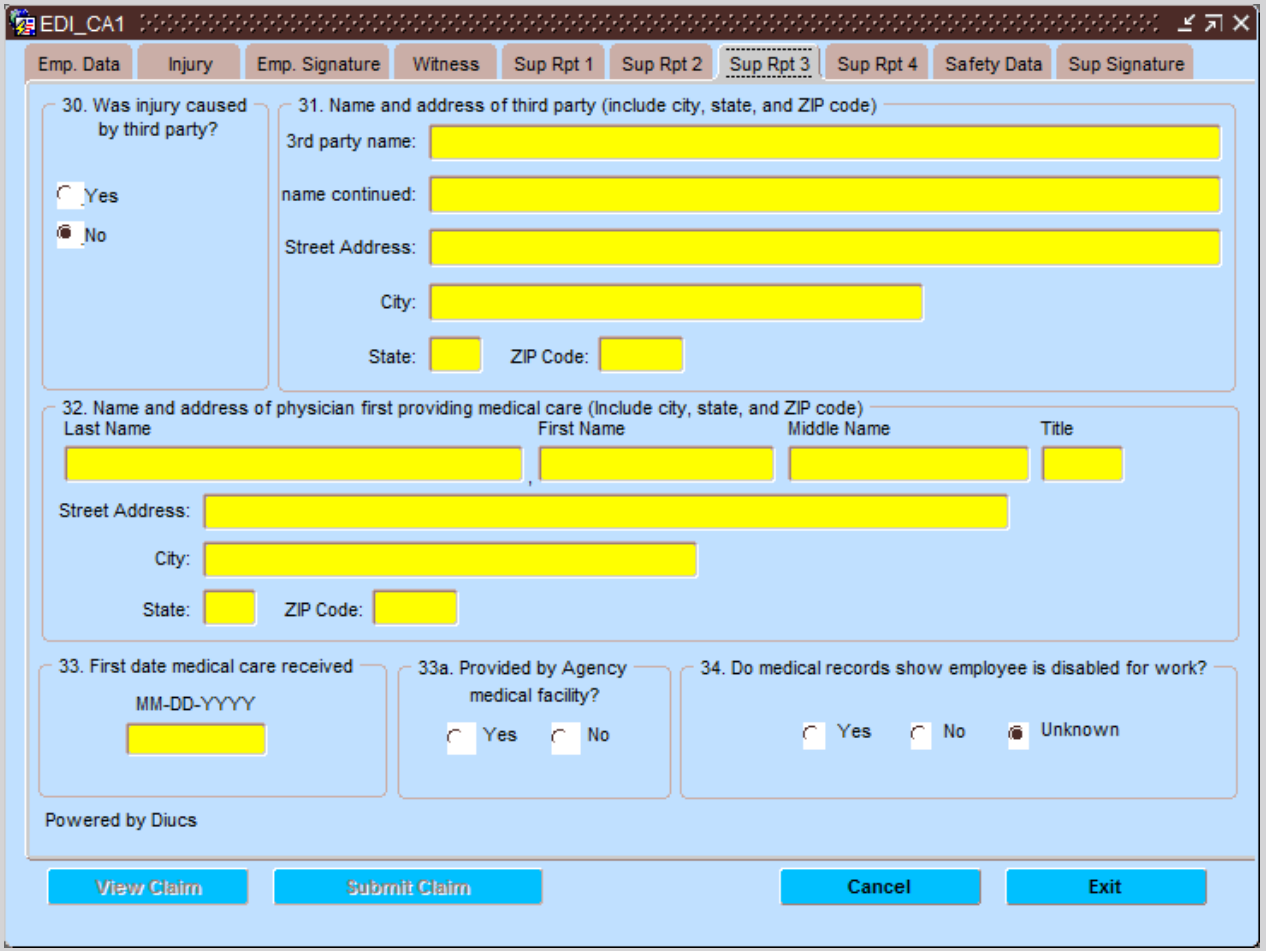


Supervisor's Report 3

Blocks 30 and 31 If there was a third party (manufacture product malfunction, non-DoD civilian, i.e.) that caused the accident that lead to the injury.
For example: If the employee was traveling in a auto vehicle to another work site and was in a car accident with a member of the public, this would be considered a third party caused injury.

Blocks 32 through 34 If the injured employee has gone to their primary care provider, an ER, or Urgent Care facility for medical attention the day of or before entering of the CA-1.

NOTE: If the employee later seeks medical attention after the claim has been submitted, provide the documentation and information to the ICPA.

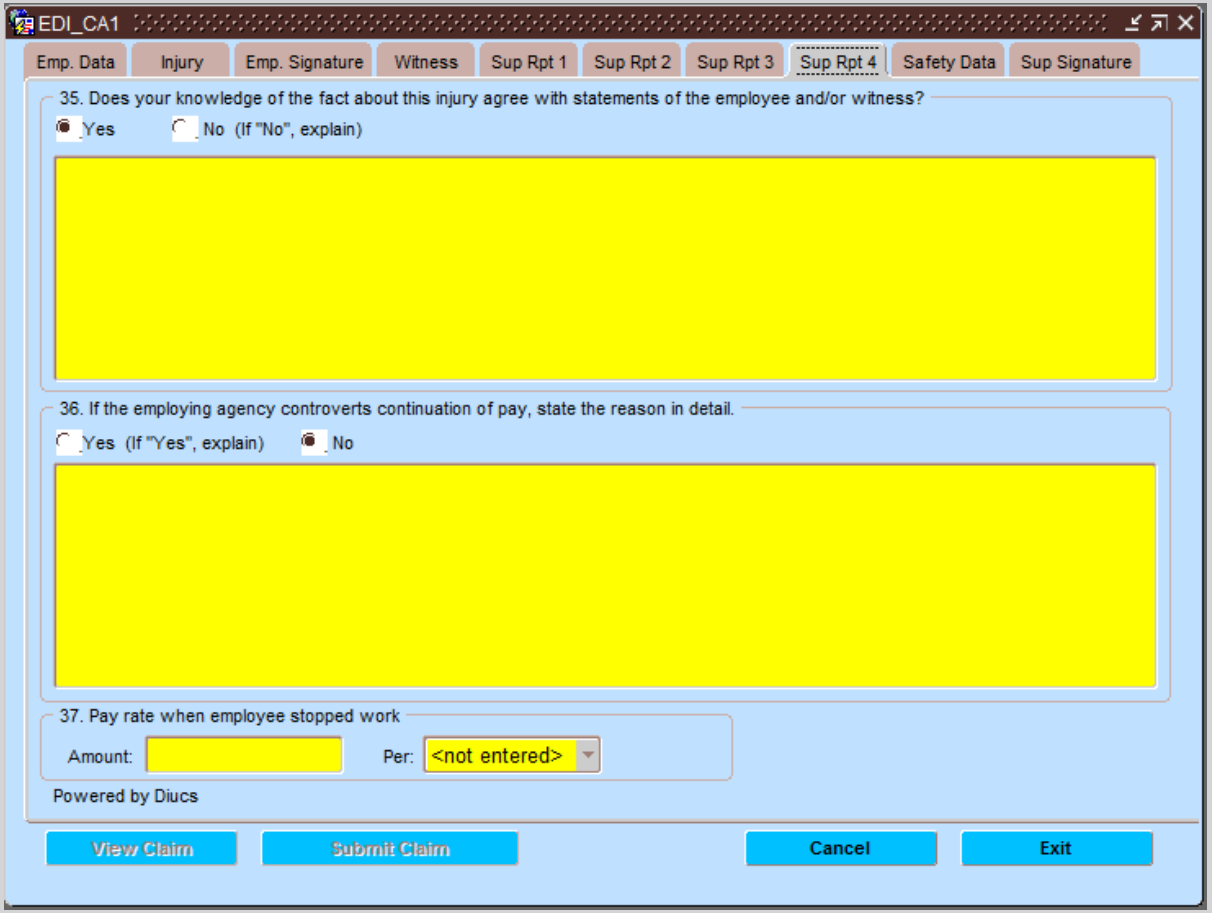


Supervisor's Report 4

Block 35 If you believe that that the statements provided by the employee and/or witness relay what really occurred to cause the injury, change the option to **"No"**, contact the ICPA to review the 5 criteria that every claim must meet to be compensable.

Block 36 If you believe the employee is not eligible to receive Continuation of Pay (COP), please contact the ICPA for a review of the nine reasons the claimant would not be eligible for COP.

Block 37 Please leave this area blank.

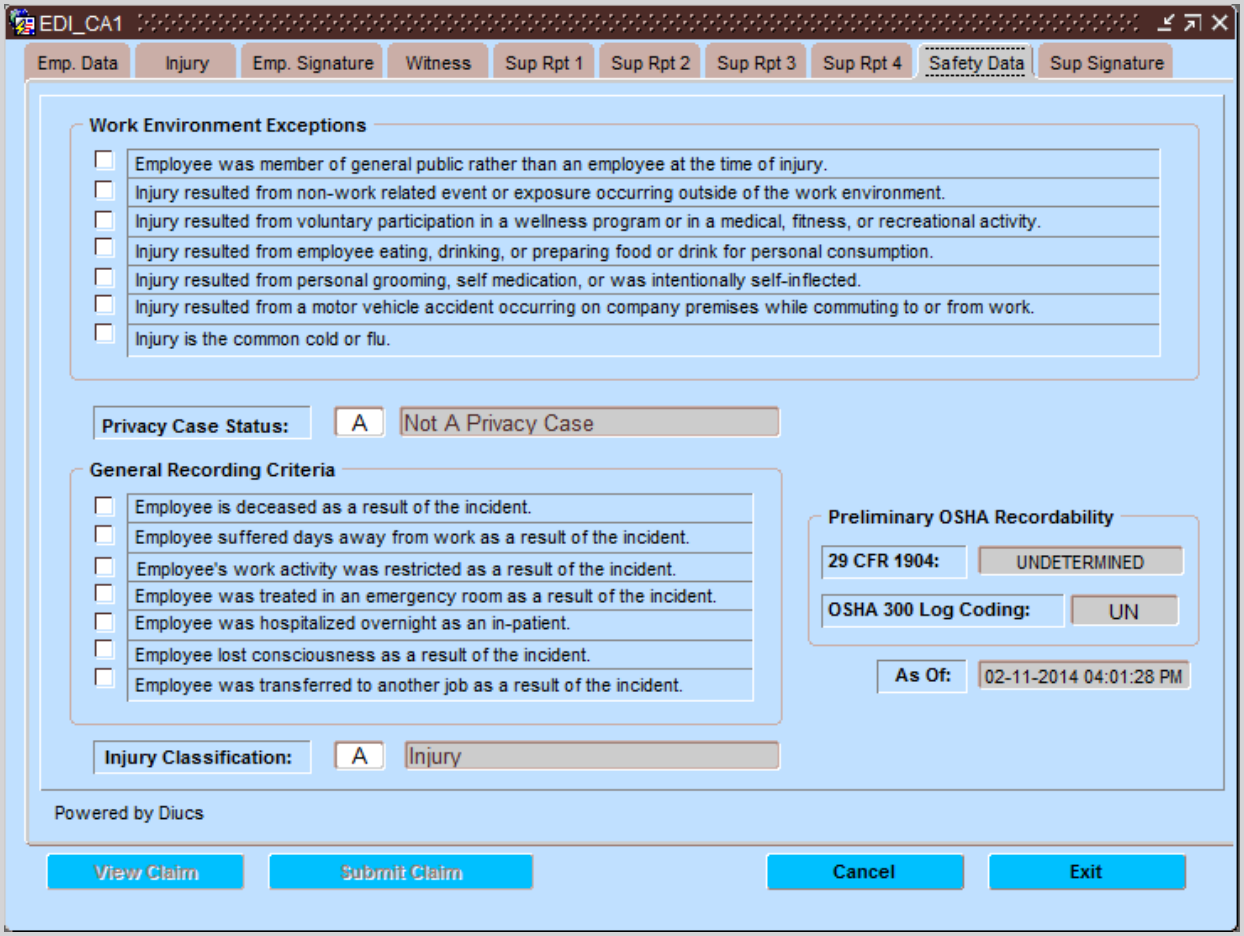


Safety Data

This tab is what will later generate the some of the information found on the OSHA 301.

Please mark all that apply to this claim as it is being filed.

Unlike the pervious tabs, the White blocks do not have to be marked for your to proceed to the next tab.



Supervisor's Signature

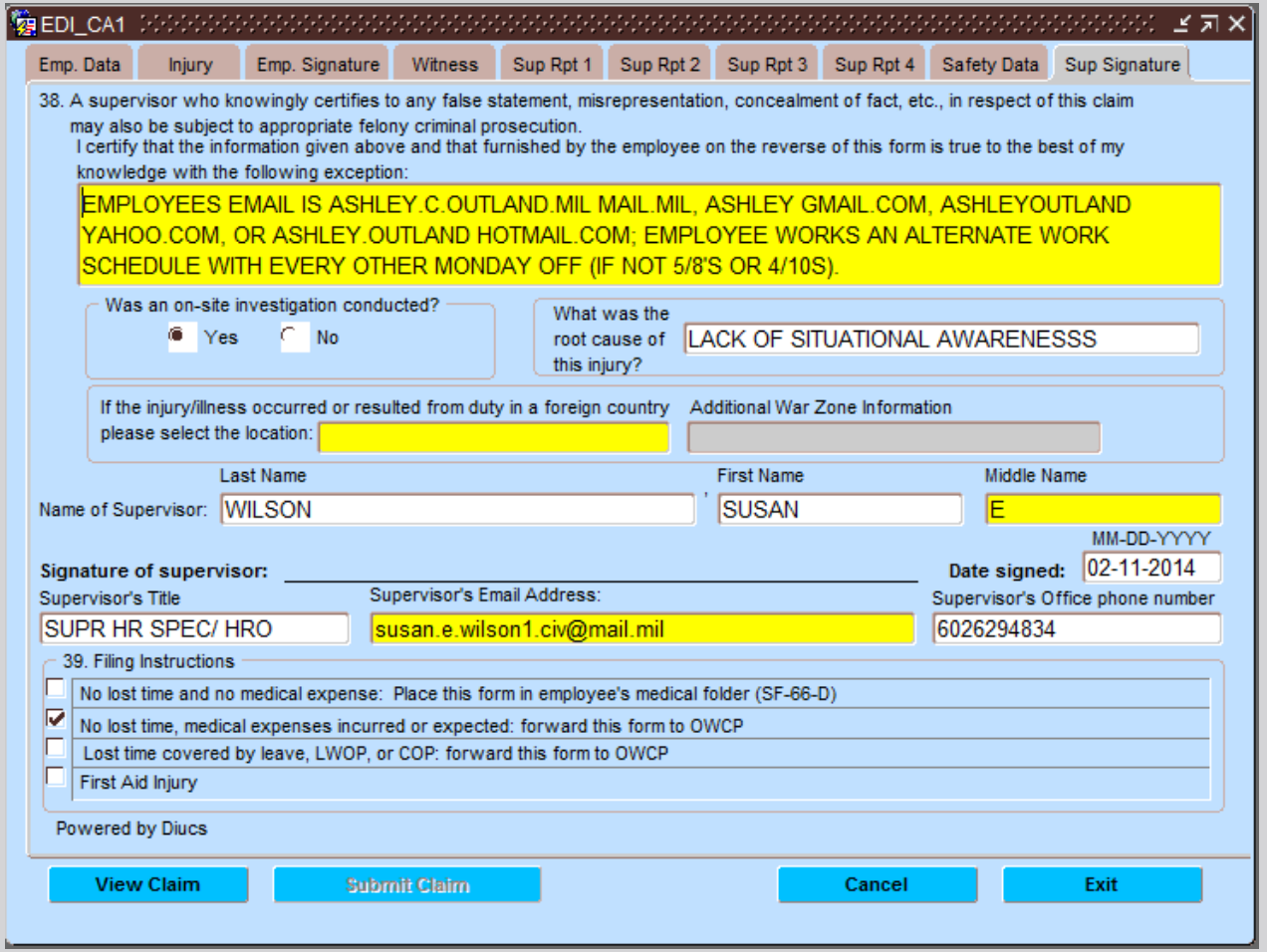
Blocks 38
If there is any information regarding the claim that was not provided in the other areas of the claim, you can use this area to provide it space provided.

For example: If the employee is on a alternate work schedule (5/4/9s), you can indicated what the day off is for the employee. (See next slide)

NOTE: Due to the issues with the email system servers, please input the employees work email and personnel email address into this area. It will be deleted prior to being submitted to DOL.

"Was an on-site investigation conducted?" should always be **"Yes"**! If you asked when, where, what, who , why and/or how, you have conducted an investigation in regards to filing this claim.

With the **"Yes"** the **"What was the root cause of this injury?"**, must be addressed.

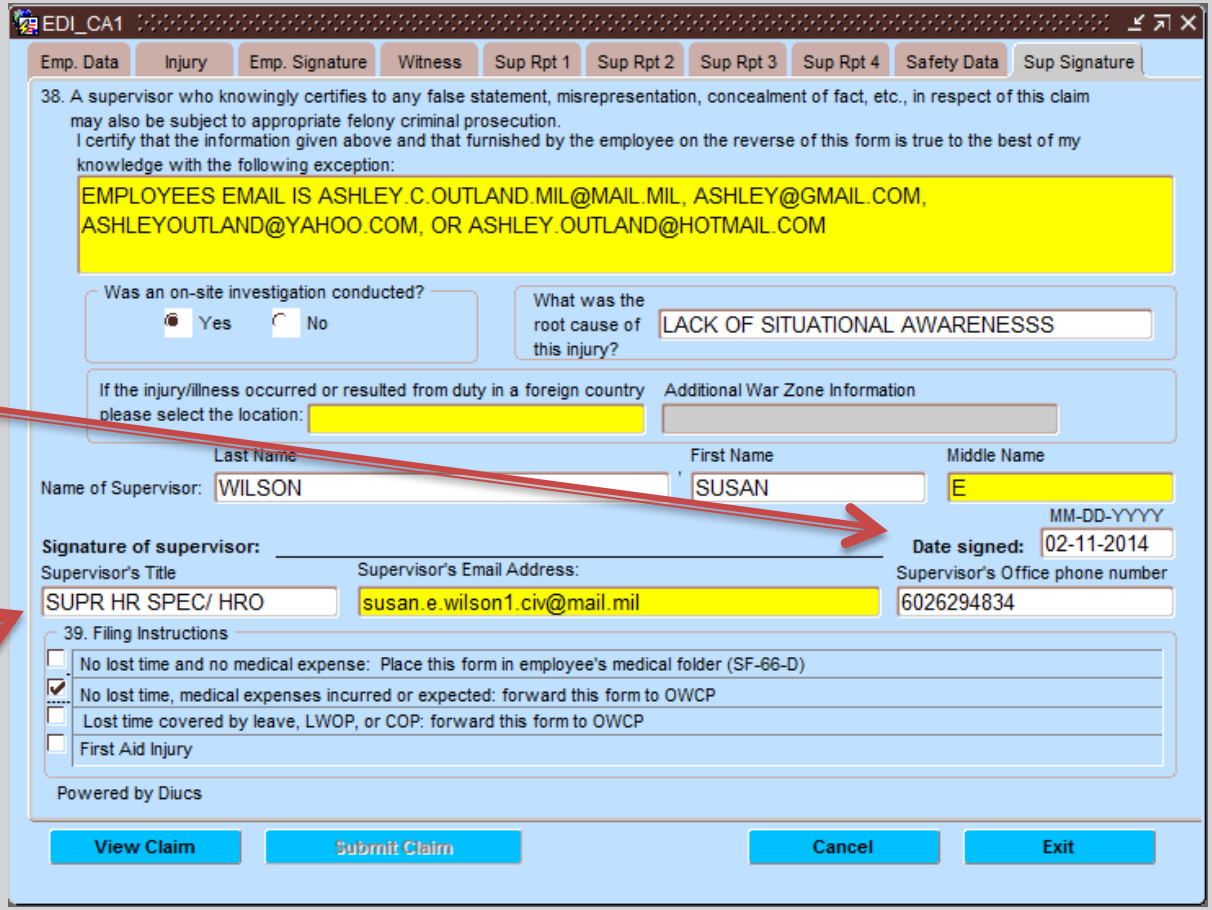


Supervisor's Signature Cont.

This is how the **"Supervisor's Signature"** tab should or could look.

NOTE 1: The date for your signature should be the same as the date in which the employee is signing the document as well.

NOTE 2: In the **"Supervisor's Title"** area, if you can abbreviate your title to make room to indicate what the main work section you fall under, i.e. HRO, G-1, AASF1, AMXS, MXS, or MOF.

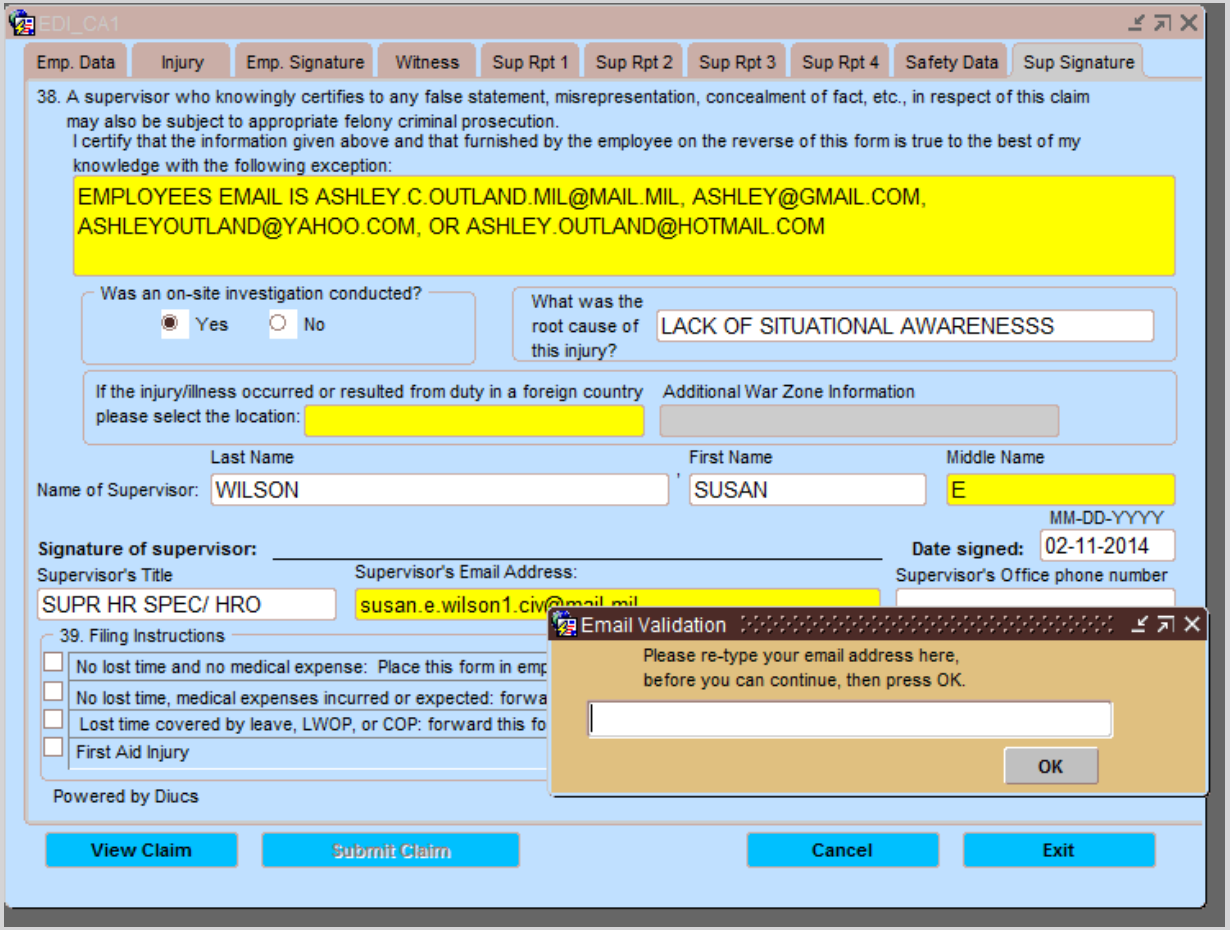


Supervisor's Signature Cont.

Please make sure to input your email address and validate it prior to submitting the claim.

If the information is not input when received by the ICPA, it will be entered based what is in the email Global address book on Outlook.

This is the email that the ICPA will use to correspond with you to request information or provide information to you.



Supervisor's Signature Cont.

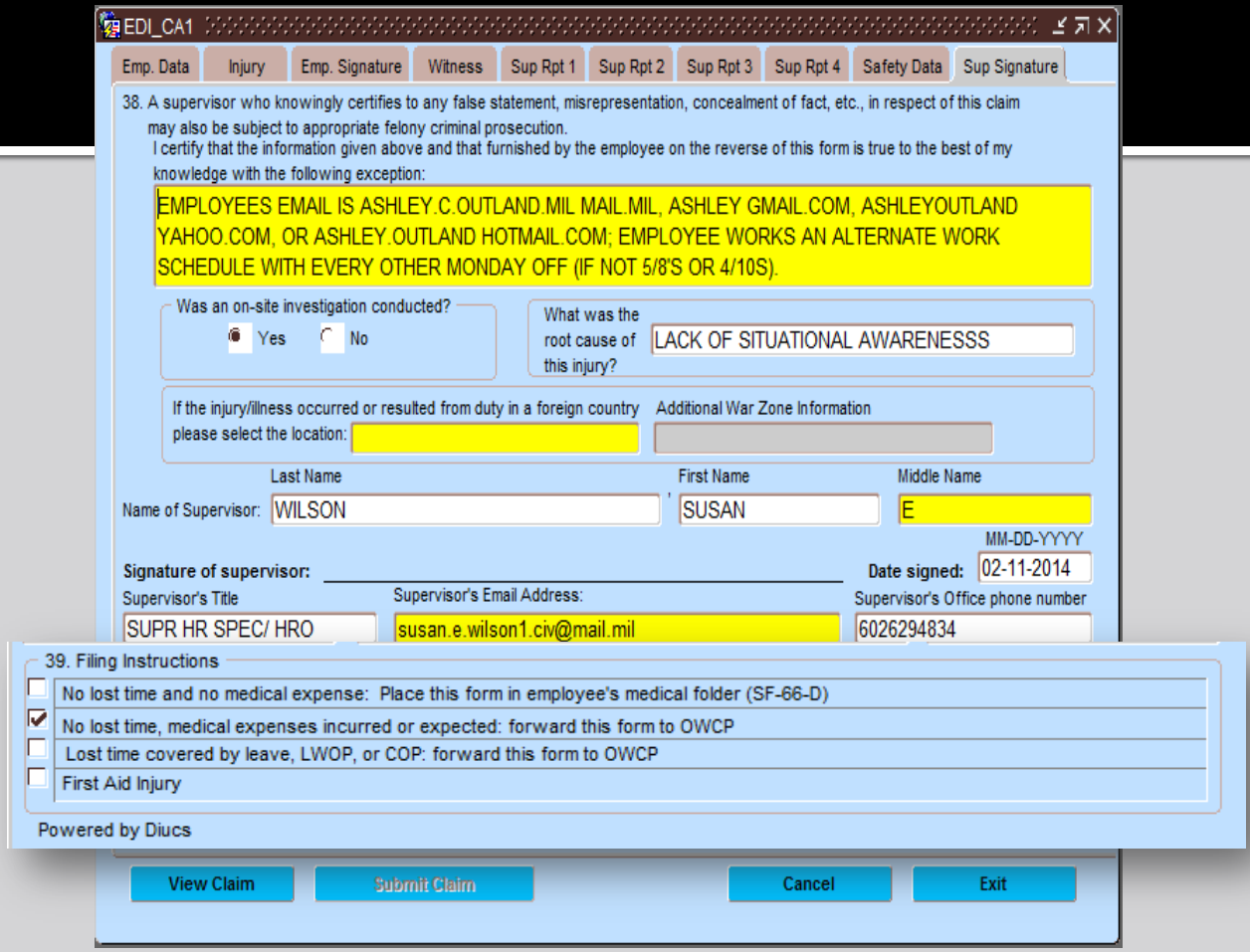
Block 39: The Filing Instructions
This will tell the system to send this claim directly to the Department of Labor for a claim number or to hold the claim for the injury was not as serious as to warrant a visit to the doctor or just the use of standard First Aid.

If the employee is has not gone to the doctor and went right back to work, then select **"No lost time and no medical expense…"**

If the employee went to the doctor on the date of injury (DOI) and return to work the same day, then select **"No lost time, medical expenses …"**

If the employee went to the doctor on the DOI and was prescribed not to return or decided not return (which in that case would be utilizing sick leave [**LS**] not COP [**LT**] regardless of eligibility), then select **"Lost time covered by …"**

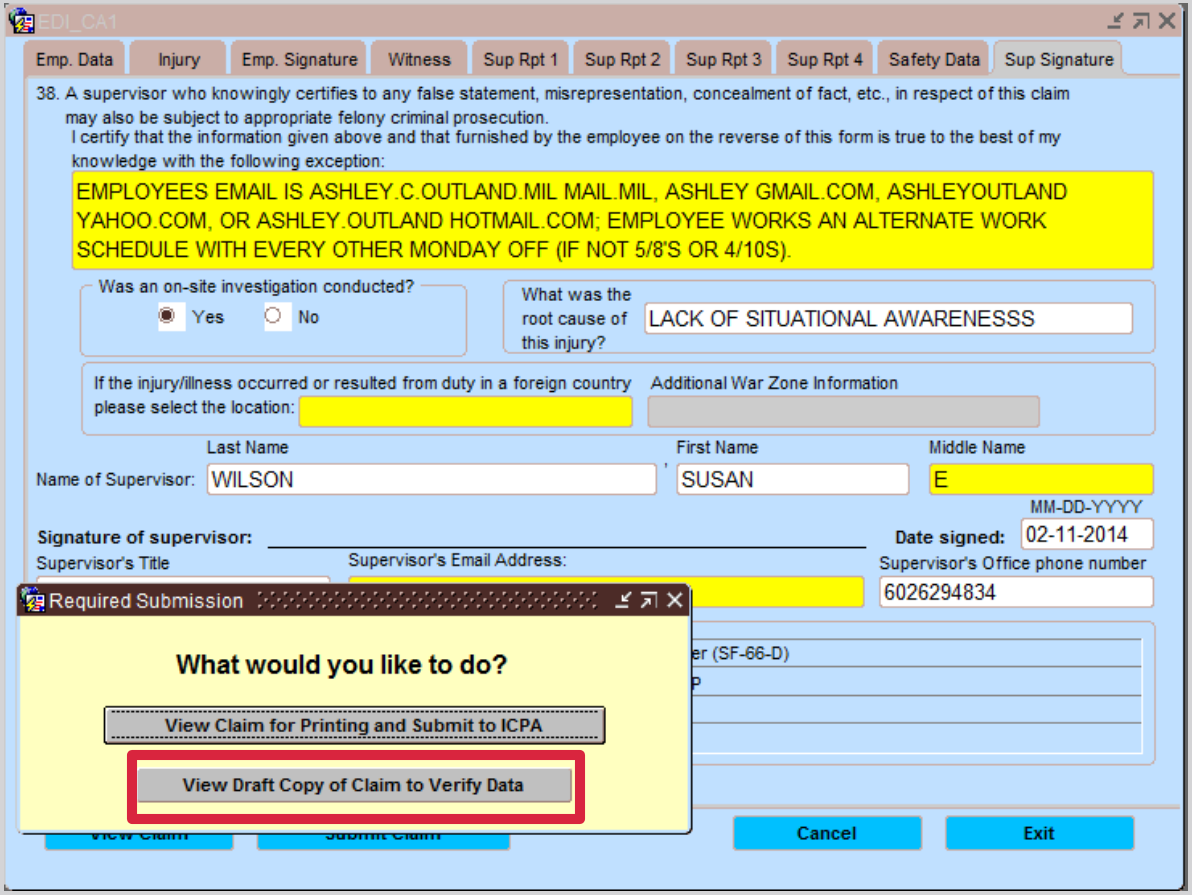
If the employee is used First Aid measures for the injury , i.e. band-aid, then select **"First Aid Injury"**.



Supervisor's Signature Cont.

When you are done inputting the information in the required areas, click on the **"Submit Claim"** button at the bottom of the tab.

The dialog box that is displayed should open. Please select the **"View Draft Copy of Claim to Verify Date".** This will open the *.pdf version of the CA-1 for review, print and signatures (employee, witness and supervisor) and send the 1st two pages of the document.

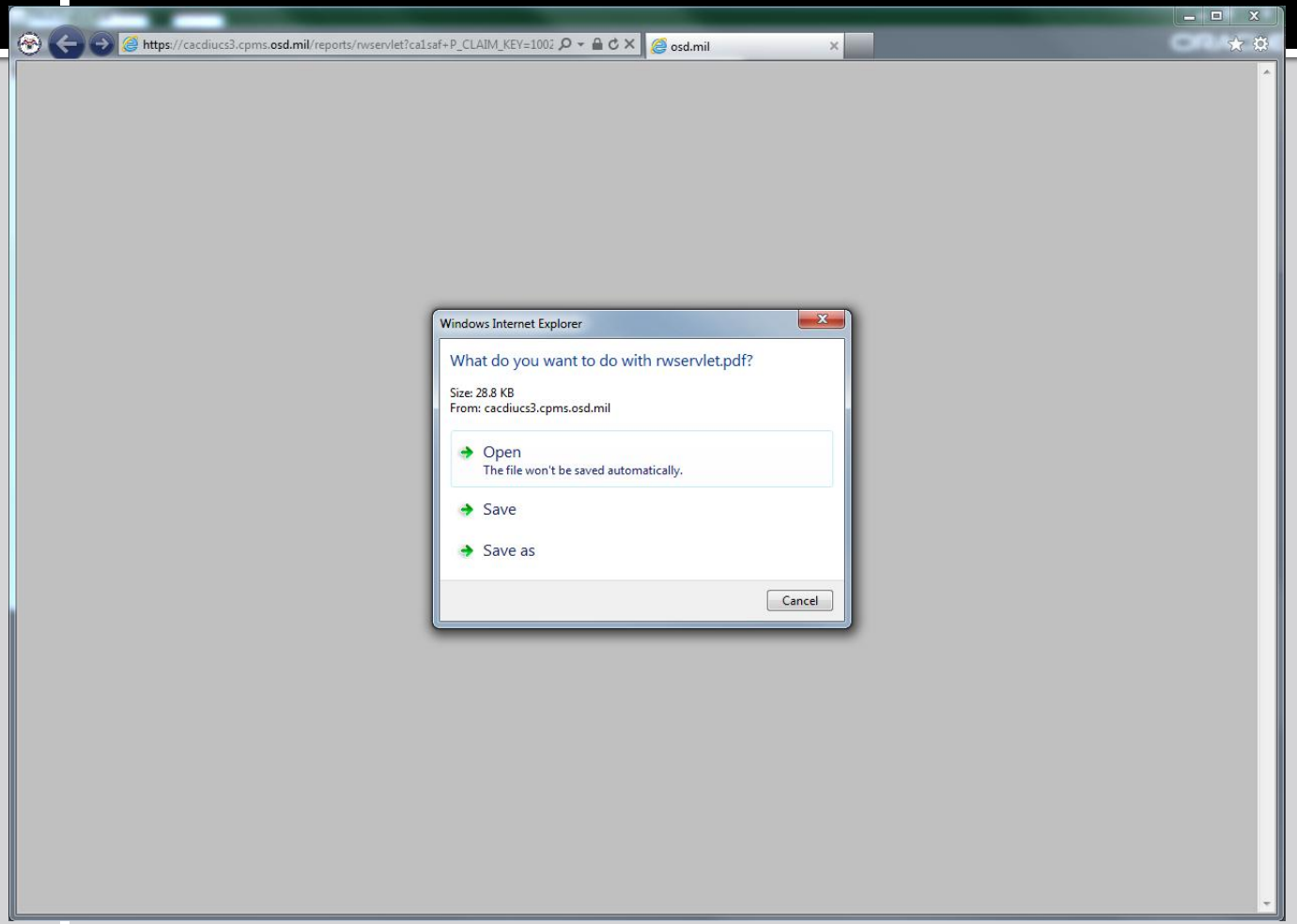


Adobe Reader Web form

When you hit the **"View Draft Copy of Claim to Verify Date"** button, a new window will then open to prompt you to **Open, Save ,or Save As** .

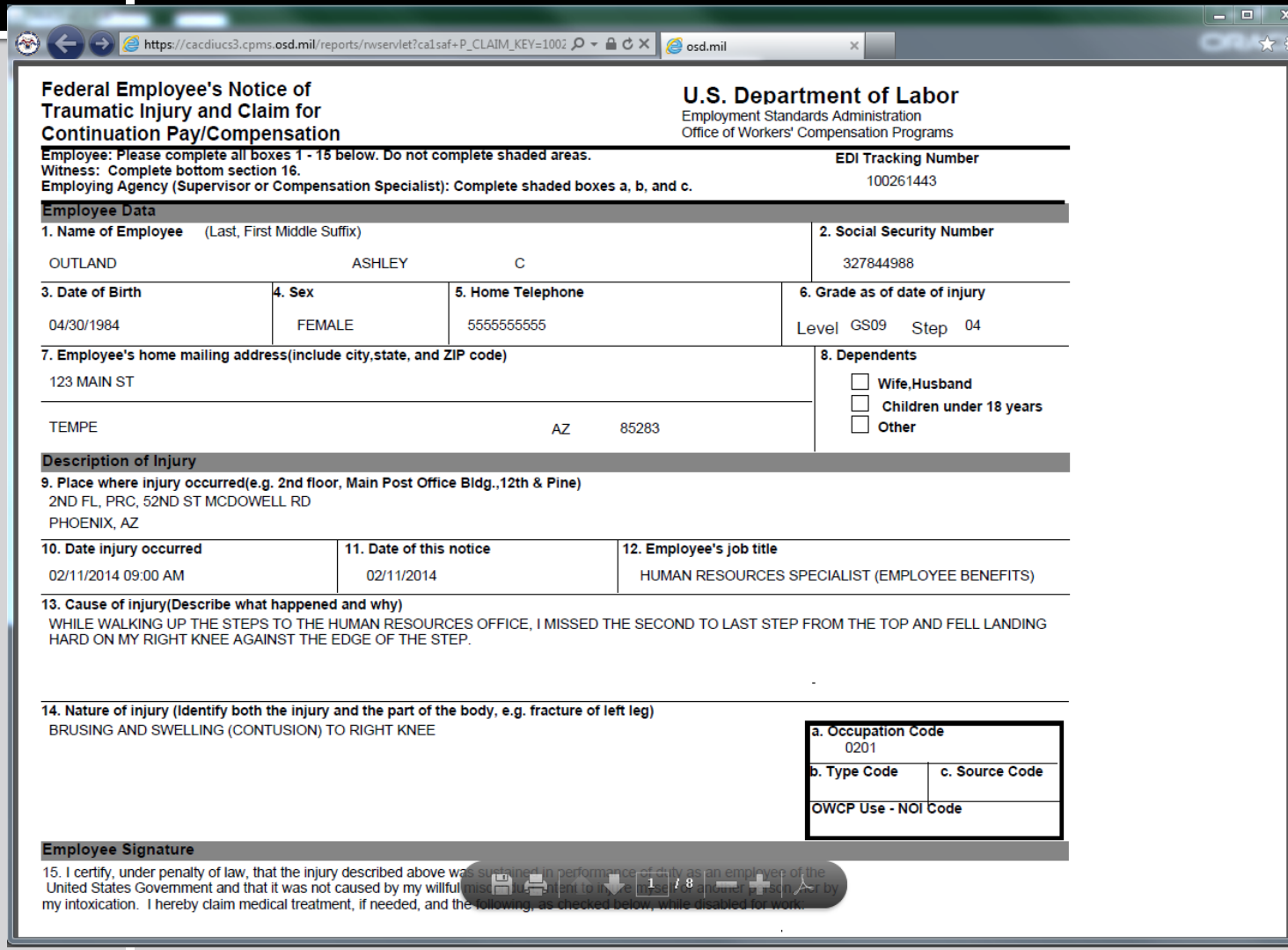
To view and print the file for signatures, please select **Open** to see the completed CA-1 form.

If there are any corrections needed to be made you can go back to the online application to make the corrections. If not possible to make corrections or additions at this time, contact the ICPA or ICPA Back-ups with the corrections.



CA-1 PDF File

Please have the employee review to make sure that their information , i.e. address and phone, are correct because that will be the methods in which DOL will use to contact and correspond with the employee.



https://cacdiucs3.cpms.osd.mil/reports/rwservlet?ca1saf+P_CLAIM_KEY=1002 osd.mil

Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

EDI Tracking Number
100261443

Employee Data

1. Name of Employee (Last, First Middle Suffix)
OUTLAND ASHLEY C

2. Social Security Number
327844988

3. Date of Birth	4. Sex	5. Home Telephone	6. Grade as of date of injury
04/30/1984	FEMALE	5555555555	Level GS09 Step 04

7. Employee's home mailing address(include city,state, and ZIP code)
123 MAIN ST
TEMPE AZ 85283

8. Dependents
☐ Wife,Husband
☐ Children under 18 years
☐ Other

Description of Injury

9. Place where injury occurred(e.g. 2nd floor, Main Post Office Bldg.,12th & Pine)
2ND FL, PRC, 52ND ST MCDOWELL RD
PHOENIX, AZ

10. Date injury occurred	11. Date of this notice	12. Employee's job title
02/11/2014 09:00 AM	02/11/2014	HUMAN RESOURCES SPECIALIST (EMPLOYEE BENEFITS)

13. Cause of injury(Describe what happened and why)
WHILE WALKING UP THE STEPS TO THE HUMAN RESOURCES OFFICE, I MISSED THE SECOND TO LAST STEP FROM THE TOP AND FELL LANDING HARD ON MY RIGHT KNEE AGAINST THE EDGE OF THE STEP.

14. Nature of injury (Identify both the injury and the part of the body, e.g. fracture of left leg)
BRUSING AND SWELLING (CONTUSION) TO RIGHT KNEE

a. Occupation Code
0201
b. Type Code | **c. Source Code**
OWCP Use - NOI Code

Employee Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct or intent to injure myself or another person or by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work.

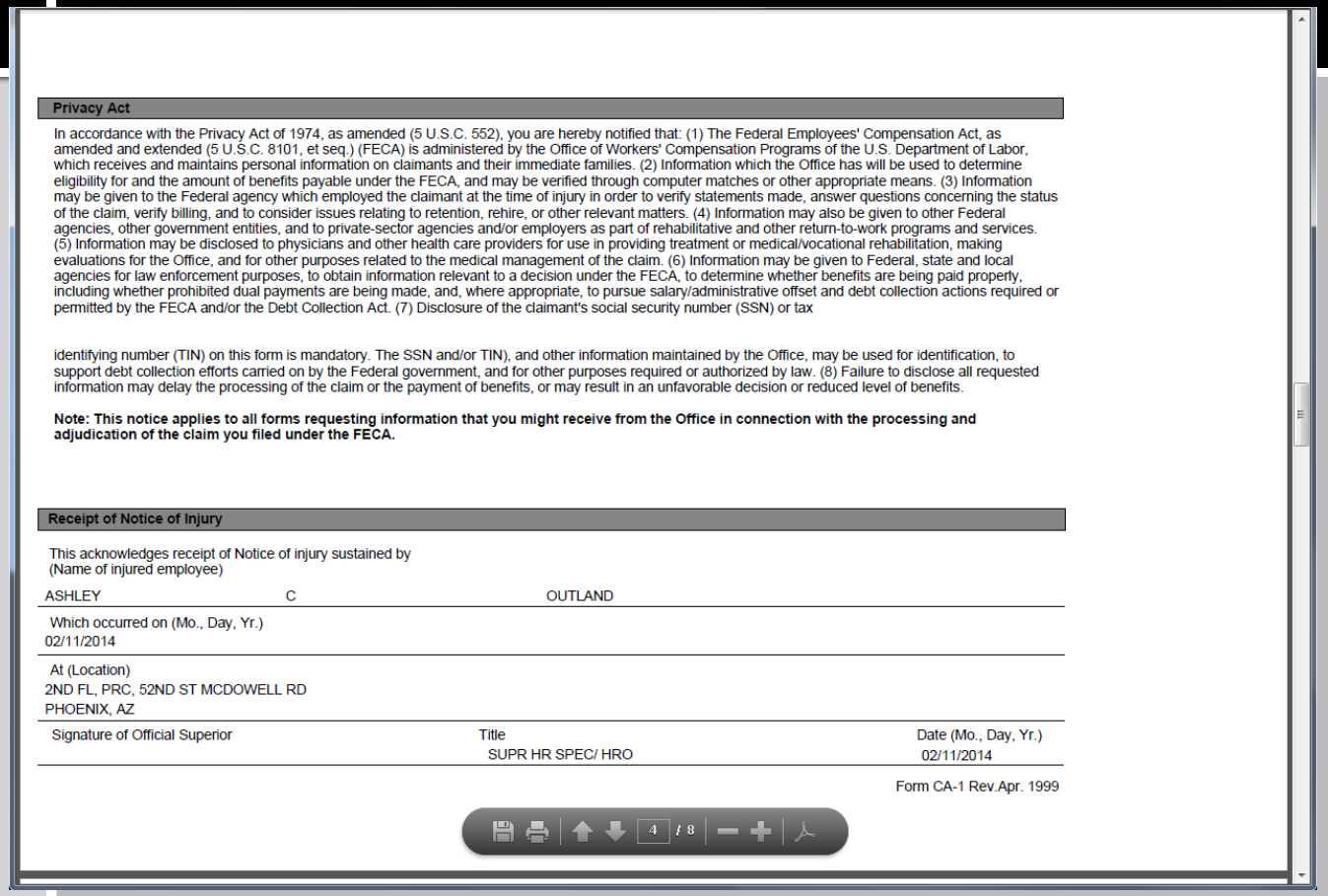
1 / 8

CA-1 PDF File Cont.

On **Page 4,** you will find an area that indicated that the employee has acknowledged that they have received a copy of the CA-1 .

There is a place for your signature.

Please sign this area as well and prior to sending the ICPA the original signed copies of the 1st two pages, please make a copy of the entire 8 page document and provide it to the employee.



Privacy Act

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended and extended (5 U.S.C. 8101, et seq.) (FECA) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor, which receives and maintains personal information on claimants and their immediate families. (2) Information which the Office has will be used to determine eligibility for and the amount of benefits payable under the FECA, and may be verified through computer matches or other appropriate means. (3) Information may be given to the Federal agency which employed the claimant at the time of injury in order to verify statements made, answer questions concerning the status of the claim, verify billing, and to consider issues relating to retention, rehire, or other relevant matters. (4) Information may also be given to other Federal agencies, other government entities, and to private-sector agencies and/or employers as part of rehabilitative and other return-to-work programs and services. (5) Information may be disclosed to physicians and other health care providers for use in providing treatment or medical/vocational rehabilitation, making evaluations for the Office, and for other purposes related to the medical management of the claim. (6) Information may be given to Federal, state and local agencies for law enforcement purposes, to obtain information relevant to a decision under the FECA, to determine whether benefits are being paid properly, including whether prohibited dual payments are being made, and, where appropriate, to pursue salary/administrative offset and debt collection actions required or permitted by the FECA and/or the Debt Collection Act. (7) Disclosure of the claimant's social security number (SSN) or tax

identifying number (TIN) on this form is mandatory. The SSN and/or TIN), and other information maintained by the Office, may be used for identification, to support debt collection efforts carried on by the Federal government, and for other purposes required or authorized by law. (8) Failure to disclose all requested information may delay the processing of the claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits.

Note: This notice applies to all forms requesting information that you might receive from the Office in connection with the processing and adjudication of the claim you filed under the FECA.

Receipt of Notice of Injury

This acknowledges receipt of Notice of injury sustained by
(Name of injured employee)

ASHLEY C OUTLAND

Which occurred on (Mo., Day, Yr.)
02/11/2014

At (Location)
2ND FL, PRC, 52ND ST MCDOWELL RD
PHOENIX, AZ

Signature of Official Superior	Title	Date (Mo., Day, Yr.)
	SUPR HR SPEC/ HRO	02/11/2014

Form CA-1 Rev.Apr. 1999

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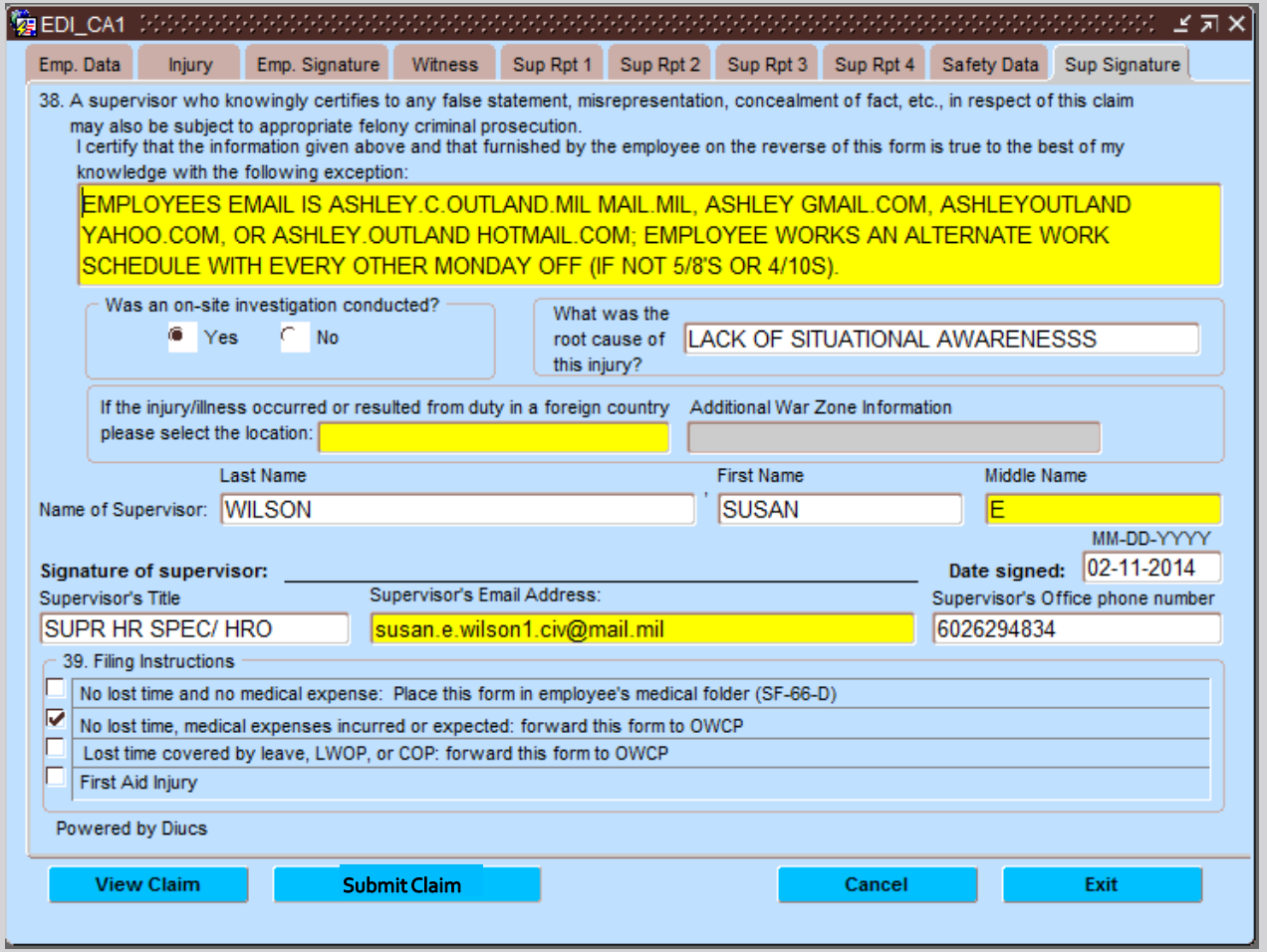
Supervisor's Signature Cont.

Once the CA-1 *.pdf file has been reviewed and printed, make sure to go back to the EDI claim window and click the **"Submit Claim"** for the electronic CA-1 to be forward to the ICPA.

REMEMBER: forward the signed CA-1 to the ICPA and provide a copy of the CA-1 to employee for their record of the claim filed.



Contact Information

Injury Compensation Program Administrator (ICPA)
SSgt Ashley Outland
Com: 602-629-4818 DSN: 853-4818
Email: ashley.c.outland.mil@mail.mil

Injury Compensation Program Administrator (ICPA) Back-Ups
Mrs. Susan E. Wilson
Com: 602-629-4834 DSN: 853-4834
Email: susan.e.wilson1.civ@mail.mil
TSgt Stacey Mitchell
Com: 602-629-4806 DSN: 853-4806
Email: stacey.a.mitchell6.mil@mail.mil

National Guard Bureau Office of Workers' Compensation Program Liaison
Mr. Russell Groves
Com: 720-250-1177
Email: russell.e.groves2.civ@mail.mil